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 Email: nursing.board@state.mn.us  
 Website: www.nursingboard.state.mn.us

## VERIFICATION OF LICENSURE

The information and evidence you are asked to provide is authorized by Minnesota Statutes and will be used to determine your qualifications for licensure. The data you supply become part of your permanent file. Until licensure is granted all application data, except name and designated address, are private data and will not be released to anyone other than the Board of Nursing staff and its agents. In the event of any legal proceedings between you and the Board, the information may be disclosed to appropriate judicial authorities or others in accordance with statutes, rules and professional standards. All data, except social security number, becomes public record when licensure is granted. Social security number and Minnesota business identification number will be used by the Minnesota Department of Revenue for tax clearance purposes and by the Board of Nursing as identifiers.

You are legally required to submit true and complete information. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

### INSTRUCTIONS FOR VERIFICATION OF LICENSURE

- Complete **APPLICANT INFORMATION**.
- Contact the licensing authority in the state/province in which you were licensed to determine if there is a fee for verification of licensure.
- Send this form and fee to the state in which you were licensed by examination. In addition, if you were first licensed in Canada by examination, send this form to the Canadian province in which you were licensed.
- Send this form to the state/province that issued the license you are currently using to practice nursing. If this is the same state in which you were licensed by examination, send only one form to the state.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications are returned •Do not use initials or abbreviations

<b>APPLICANT INFORMATION</b>			
LAST NAME	FIRST NAME	MIDDLE NAME <input type="checkbox"/> No middle name	
MAIDEN NAME		OTHER LAST NAME(S)	
CURRENT ADDRESS		CITY, STATE/PROVINCE, ZIP/POSTAL CODE	
ORIGINAL LICENSE NUMBER	ISSUE DATE (Month/Day/Year)	SOCIAL SECURITY NUMBER <small>[Required by Minn. Stat. 270C.72 (2005)]</small>	BIRTH DATE (Month/Day/Year)
NAME OF NURSING SCHOOL (No initials)		CITY/STATE/PROVINCE OF NURSING SCHOOL	
I hereby authorize the _____ licensing authority to furnish the Minnesota Board of Nursing the information requested on the reverse side of this form. <span style="display: block; text-align: center; font-size: small;">State/Province</span>			
<b>LEGAL SIGNATURE OF APPLICANT</b>			DATE (Month/Day/Year)

Reverse side must be completed by Licensing Agency.

**THIS SECTION IS FOR LICENSING AGENCY USE ONLY**

**LICENSURE INFORMATION**

LICENSE NUMBER OF NURSE REQUESTING VERIFICATION <input type="checkbox"/> RN <input type="checkbox"/> LPN	DATE ISSUED (Month/Day/Year)
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CURRENT LICENSURE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> LAPSED <input type="checkbox"/> INACTIVE	EXPIRATION DATE (Month/Day/Year)	LICENSED BY <input type="checkbox"/> EXAMINATION <input type="checkbox"/> ENDORSEMENT
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Has this license ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, limited, placed on probation, etc.)

Yes       No      If yes, attach explanation and copy of the public documents.

NAME OF NURSING EDUCATION PROGRAM COMPLETED	APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO
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CITY/ STATE/PROVINCE OF NURSING PROGRAM	GRADUATION DATE (Month/Day/Year)
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<b>STATE BOARD TEST POOL EXAMINATION</b>						<b>NCLEX®</b>	
<b>Registered Nurse</b>					<b>LPN</b>	<b>RN</b>	<b>LPN</b>
<b>Medical Nursing</b>	<b>Psychiatric Nursing</b>	<b>Obstetrical Nursing</b>	<b>Surgical Nursing</b>	<b>Nursing of Children</b>			
<b>Examination Results</b>							
<b>Series/Form Number</b>							
<b>Examination Date</b>							

I certify that the above information accurately represents the information on file with the Board for the above named nurse.

**OFFICIAL SEAL**

	Signature
	Title
	State/Province
	Date